DR. JOSEPH S. BORREGGINE, PODIATRIST
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PATIENT INFORMATION FORM
(PLEASE PRINT)

DATE: ___/___/___

Patient Name: _____ _____ ___ DOB: ___/___/___ AGE: ___ SEX: M F
LAST FIRST MI
Home Address: _____ City/State: _____ Zip: _____
May we leave a message?
Home Phone #: (____)____-_____ YES NO
Alternate Phone#: (____)____-_____ YES NO
Email: _____ YES NO
Primary Language: _____

Do you have a legal Guardian or healthcare power of attorney? Yes No
If Yes, Name: _____ Relationship: _____ Phone #: (____)____-_____

Emergency Contact: _____ Relationship: _____ Phone #: (____)____-_____
Primary Care Doctor: _____ Who Referred you to us? _____
Pharmacy: _____ Location: _____ Phone #: (____)____-_____

Is there a family member or other person you would like for us to share your medical information?
_____ Yes Name(s) _____ No

Who is responsible for payment? _____ Relationship to patient? _____
Address: _____ City/State: _____ Zip: _____ Phone #: (____)____-_____

Insurance Information:
We will make a copy of your insurance card(s) at your first appointment, please make sure you have your insurance card(s)with you.

PATIENT NAME: ||PAT_FNAME|| ||PAT_LNAME||
DATE OF BIRTH: ||PAT_DOB||

Please list all medications you are currently taking (include prescriptions, over the counter meds and herbal supplements):
Name Dose How often do you take?
_____
_____
_____
_____
_____
_____
_____

Please list all prior surgeries:
Type of Surgery Date Type of Surgery Date
_____ _____
_____ _____
_____ _____

SOCIAL HISTORY
Marital Status:
(___)Single (___)Married (___)Partnered (___)Separated (___)Divorced (___)Widowed

Use of alcohol:
(___)Never (___)No Longer Use (___)History of Alcohol Abuse
(___)Current Use- Type _____ (___)Rare (___)Occasional (___)Moderate (___)Daily

Use of Tobacco:
(___)Never (___)Quit - How long ago? _____ (___)Smoke ___ Packs/Day for ___ Years

Use of Recreational Drugs: (___)Never (___)Quit - How long ago? _____ Type _____
(___)Current use - Type _____ (___)Rare (___)Occasional (___)Moderate (___)Daily

Employer: _____ Occupation: _____

How much are you on your feet at work? (___)10% (___)25% (___)50% (___)75% (___)100%

Do others depend upon you for their care? (___)Children-age(s) ___ (___)Pet(s)-What kind? _____
(___)Elderly or disabled family member (___)Other_____

Exercise: (___)Never (___)Rare (___)Occasional (___)Weekly (___)Several times a week (___)Daily

Types of Exercise: _____

Shoe Size: _____ Women's Men's N M W XW

PATIENT NAME: ||PAT_FNAME|| ||PAT_LNAME||
DATE OF BIRTH: ||PAT_DOB||

FAMILY HISTORY

Do you have a family history of:
(___)Diabetes (___)Cancer (___)Heart Disease (___)High Blood Pressure
(___)Stroke (___)Coronary Artery Disease (___)Thyroid Disease (___)Rheumatoid Arthritis
(___)Other_____
Grandmother Grandfather Mother Father Brother Sister (circle one)

YOUR MEDICAL HISTORY

Allergies: (___)None Known (___)Medications _____
(___)Anesthesia _____ (___)Foods _____
(___)Tape (___)Latex (___)Shellfish (___)Iodine (___)Other _____

Have you ever had the following?

Acid Reflux Y N Fibromyalgia Y N Neuropathy Y N
Anemia Y N Gout Y N Open Sores Y N
Arthritis Y N Heart Attack Y N Pneumonia Y N
Asthma Y N Heart Disease/failure Y N Polio Y N
Back Trouble Y N Hepatitis Y N Rheumatic fever Y N
Bladder infections Y N Hiv/Aids Y N Sickle Cell Disease Y N
Abnormal Bleeding Y N High Blood Pressure Y N Skin Disorder Y N
Blood Clots Y N Kidney Disease Y N Sleep Apnea Y N
Blood Transfusion Y N Liver Disease Y N Stomach Ulcers Y N
Bronchitis/emphysema Y N Low Blood Pressure Y N Stroke Y N
Cancer Y N Migraine Headaches Y N Thyroid Disease Y N
Diabetes Y N Mitral Valve Prolapse Y N Tuberculosis Y N
Other conditions: _____

CURRENT PROBLEM

We will ask you about your current foot pain when we see you.